

Kitchen Staff Health Declaration Form

Full Name

Position

Date

Health Screening

Do you have any of the following symptoms?

☐

Fever

☐

Cough

☐

Sore Throat

☐

Nausea/Vomiting

☐

Diarrhea

☐

None of the above

Have you been diagnosed with or been in contact with any infectious diseases in the past 14 days?

Any cuts, wounds, or skin infections on hands or arms?

Additional Comments

I declare that the above information is true and accurate to the best of my knowledge.

Signature